Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Insurance and Real Estate Committee
In support of HB 6612
March 12, 2013

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems. One component of OHA's statutory mission is to assess the state of the mental health systems in Connecticut and, where necessary, identify solutions in collaboration with key stakeholders and consumers.

Thank you for the opportunity to speak with you concerning HB 6612, An Act Concerning the Health Industry Grievance Process for Adverse Determinations, The Office of the Healthcare Advocate and Mental Health Parity Compliance Checks. This bill addresses several elements of the utilization review process that have long needed modification to more equitably serve the consumers of Connecticut, as well as several key recommendations of the Program Review and Investigations Committee's study on the adequacy of insurer coverage and enrollee utilization of substance use treatment, all of which OHA enthusiastically supports. These key concepts include changing the timeframe for insurer's urgent utilization review processes from seventy-two to twenty-four hours, as well as the automatic classification of mental health and substance use claims as urgent requests, promoting compliance with federal law by waiving consumer's liability during the concurrent review process, the expansion of the

content of adverse determination notice to more adequately inform consumers about the basis for denial as well as their options, including more detailed disclosure of OHA's services, and ensuring that the Insurance Department oversight of mental health parity compliance become more robust and comprehensive. Additionally, HB 6612's acknowledgment of the need for a more clinically appropriate uniform definition of clinical peer, as well as the need for appropriate clinical criteria for insurer's utilization review process, significantly enhance consumer protections, principles of equity and sound public policy. We are aware that there is additional proposed legislation that addresses elements of this issue, and we support those concepts as well.

Mental illness in the United States has significant and wide ranging impacts. Estimates place the direct and indirect costs from $34 billion[1] to $57 billion[2] annually. Not only are the social and economic effects of mental illness vastly misunderstood, but individuals suffering with severe mental illness die an average of 25 years sooner than those without mental disease.[3] In addition, OHA has seen a trend that is of concern. Since 2008, the number of cases that we have received has increased more than two and a half times, from 185 to 524.[4] Every day, we receive calls from consumers who have been impacted by the complexity and inequity of the existing system. One example involves the family of a seventeen year old young man who sought OHA's help when his continued inpatient hospital level of care was denied by his carrier. In denying coverage for step down care, the insurer disregarded the young man's self-harm, threats against peers at school, increased isolation, his being bullied by peers at school and destruction of property. In collaboration with another state agency, OHA argued to the insurer that continued inpatient coverage was required, followed by a step-down that was overturned, providing coverage for continued inpatient coverage an initial thirty day stay in the step down facility. OHA continues to pursue coverage for ongoing needs for this young man. Accordingly, in October 2012, OHA held a public forum focusing on barriers to access and delivery of mental health and substance use treatment and services. Our findings[5] indicated a need for an overall vision of an integrated behavioral health system, with an emphasis on early intervention and prevention as well as a comprehensive and innovative approach to delivery of these necessary services.

The recommendation that prospective or concurrent utilization review requests involving treatment for a substance use or co-occurring disorder be treated as urgent care requests, as well as the requirement that insurers complete the review process and issue a decision within twenty-four hours of the receipt of such a request instead of the current seventy-two hours, acknowledges the clinical reality that, in these

cases, delays in the onset of treatment may be the difference between recovery or relapse. HB 6612 expands on the protections under federal law. 29 CFR 2560.503-1(f)(2)(i) requires that: "the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan."

Individuals with substance use and addiction struggle on a daily basis, often complicated by an underlying co-occurring mental disorder. Delays in access to appropriate levels of care can not only impede a person's treatment, but could result in a rapid deterioration of any progress made, requiring a repeated or lengthened course of treatment and the additional costs associated with that care. Defining these requests as urgent care requests allows treatment decisions may be made in a timely and appropriate manner. The Program Review and Investigations Committee's ("PRI") Study on Access to Substance Use Treatment for Insured Youth identified this as an important step to the removal of a clinically inappropriate barrier, stating that "*Research, providers, and advocates agree that when a person with a substance use or co-occurring disorder is ready to engage in treatment, care must be immediately available.*"[6]

Section 2(b)(1)(B) of HB 6612 requires that services under concurrent review be covered without liability to the consumer for the duration of the review, affirming protections already in force under federal law. 29 C.F.R. 2560.503-1(f)(2)(ii)(A) requires that carriers "must comply with the requirements set forth in which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advanced notice and an opportunity for advanced review."

Connecticut's definition of "clinical peer" is inconsistent with surrounding states and the protection of consumers who purchase insurance to cover medically necessary care. HB 6612 corrects this by ensuring that, for any adverse determination, the requested service or treatment and available clinical information has been reviewed by a clinician with training, experience and, where indicated, specialization relevant to the claim being reviewed. States surrounding Connecticut have more vigorous peer reviewer standards; e.g., Massachusetts[7], Rhode Island[8] and New York[9].

HB 6612 requires that clinical reviewers possess specific experience and training in age appropriate mental health and substance use treatment, recognizing that substance use and associated co-morbidities

are unique diagnoses and deserve clinically appropriate consideration. The requirement that clinical reviewers for mental health and substance use conditions possess specialized training in the subject matter under review merely acknowledges the professional standards for specialization, and was an additional finding of the PRI study.[10] For example, the American Academy of Child and Adolescent Psychiatry requires "two years of additional specialized training in psychiatric work with children, adolescents, and their families in an accredited residency in child and adolescent psychiatry."[11] This clinical standard should be applied to standard utilization review processes, especially given the serious implications that improper decisions can have on policyholders.

HB 6612 also expands consumer protections by requiring that a standard and appropriate set of clinical criteria be used for all substance use and co-morbid utilization reviews, another recommendation promoted by the PRI study which found that mental health and substance use criteria used by some carriers for residential treatment utilization reviews "did not match up well to the ASAM-PPC 2R, or include references to peer-reviewed literature or professional association guidelines that would justify the deviations. One plan's residential criteria seemed especially at odds with the ASAM manual...."[12] OHA also determined that this was the case.

By providing a standard statutory requirement of recognized mental health and substance use criteria, carriers, providers and, most importantly, consumers can know how treatment requests are to be assessed. More importantly, policyholders should have more predictable and consistent access to care across carriers. Using the widely accepted and clinically appropriate American Society for Addiction Medicine's Patient Placement Criteria, or alternate criteria approved by Department of Mental Health and Addiction Services and the Department of Children and Families, requests for treatment for substance use and associated co-morbidities will ensure that requests for services will at last be assessed with standard and clinically appropriate criteria by an experienced and clinically appropriate provider.

HB 6612's affirmation that all adverse determinations must be provided to the member in writing, with a detailed list of any criteria used in the utilization review process, as well as a detailed and case specific explanation why the requested treatment or service was denied, is critical to ensuring that consumers receive adequate notice of, as well as to enhance their ability to understand, the basis for the denial. OHA's view is that existing law does not provide the level of rationale that a policyholder should receive in order to understand the basis for the denial. Denials often generally cite criteria without providing

specific information on the policyholders' circumstance that tie the criteria to the patient. Further, there is little evidence from OHA's review of denial letters that plans are in fact deferring to the statutory definition of medical necessity as the final arbiter of medical necessity rather than their criteria.

The clarification of the Connecticut Insurance Department's ("CID") authority to specifically include routine assessments for carrier compliance with mental health parity laws expands the protections available to consumers and merely codifies the common goal of serving consumers and enforcing existing law.

Finally, as OHA is the federally designated consumer assistance program under the Affordable Care Act, denial notices must contain information about OHA's ability to assist consumers with grievances and appeals. Current law does not require denial notices to contain this information. HB 6612 corrects this deficiency in current law by enhancing the notice to consumers about OHA's free assistance available to them from OHA, as well as the opportunities for OHA's assistance in appealing the adverse determination, empowering consumers to take full advantage of the full range of options available to them under law. HB 6612 also makes several minor modifications to OHA's statutes, clarifying our role and scope of authority, as well as simplifying them.

As Connecticut prepares to offer plans through its Exchange, resolution of these issues is critical so that as tens of thousands of residents enter into the health insurance market under new insurance plans, they will experience a common sense, equitable and understandable process. Now is the time to make these long overdue changes and to ensure that we vastly improve access to medically necessary mental health and substance use services for our residents.

Thank you for providing me the opportunity to deliver OHA's testimony today. We look forward to continuing to collaborate and advocate for the consumers of Connecticut in this important matter. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

---

[1] http://www.nami.org/Template.cfm?Section=Policymakers_Toolkit&Template=/ContentManagement/ContentDisplay.cfm&ContentID=19043

[2] http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml?WT.mc_id=rss

[3] http://www.politifact.com/ohio/statements/2013/jan/02/terry-russell/nami-ohio-leader-terry-russell-says-people-mental-/

[4] http://www.ct.gov/oha/lib/oha/documents/publications/oha_2012_annual_report_final_r.pdf

[5] http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf
[6] http://www.cga.ct.gov/pri/2012_atsu.asp
[7] M.G.L. ch. 1760, § 12.
[8] R.I.G.L. § 23-17.12-9
[9] Art. 49, Title 1, §4900
[10] http://www.cga.ct.gov/pri/2012_atsu.asp
[11] http://www.aacap.org/cs/root/facts_for_families/the_child_and_adolescent_psychiatrist
[12] http://www.cga.ct.gov/pri/2012_atsu.asp